AZCEND
Changing Lives Since 1966

Southeast Community Action Program
Prescreening and Needs Evaluation

*****CAP Use Only******
Date rec'd:_____
Appt. Date: _____
Appt. time: _____
Where: CH or GL

Applicants Name: _____ Date: _____

Current Address: _____ Apt/Unit: _____

City: Chandler Gilbert Sun Lakes Queen Creek State: AZ Zip Code: _____
(PLEASE CIRCLE)

Mailing Address: _____
Street or PO Box # City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

Family Type:
- ☐ Single Parent/ Female
- ☐ Single Parent/ Male
- ☐ Two Parent household
- ☐ Single person
- ☐ Two adults(no minor children)
- ☐ Other

Living Arrangement / Dwelling:
- ☐ House
- ☐ Mobile Home
- ☐ Apartment
- ☐ Other

Housing Type:
- ☐ Rent
- ☐ Own
- ☐ Subsidized/Section 8
- ☐ No Pay
- ☐ N/A
- ☐ Homeless

Do you receive Food Stamps? Yes No
Would you like to sign up for SNAP (food Stamps)? Yes No
Are you a former employee of AZCEND or CAP office? Yes No
Are you a current volunteer or have ever volunteered with AZCEND or CAP office? Yes No
Are you an unemployed Veteran? Yes No
Is anyone in your household on AHCCCS: Yes No
Who is your AHCCCS provider? _____

What assistance are you requesting today? Check all that apply
- ☐ Past Due Rent
- ☐ Past Due Mortgage
- ☐ First Months Rent
- ☐ Utility (electric, water, gas)
- ☐ Utility Deposit
- ☐ Emergency Home Repairs (please explain):_____
- ☐ Weatherization (insulation, weather proofing etc.)
- ☐ Case Management (budgeting, goal setting, etc.)
- ☐ Job Training

Do you have children 5 and under? _____ Yes _____No
Are you interested in receiving more information about children's programs? _____ Yes _____No

Please Complete the following with information about the your household

*****DO NOT COMPLETE GREY AREAS*****

NAME **First, Middle, Last**	**Gender**	**Date of Birth**
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	

Energy Education: **Y** **N**
Child Support Referral to Custodial single-parent: **Y** **N** **N/A**
Migrant Farm Worker: **Y** **N** Seasonal Farm worker: **Y** **N**
Income Type: **Emply** **Emply&Ben** **Other** **No income**
Benefits: **CA** **GA** **SSI** **SS** **Pension** **UI**

Answer the following questions ONLY if providing assistance with state EA and/or TANF fund sources:

All employable HH members have complied with employment or employment training requirements? **Y** **N**

MONTHLY INCOME		**MONTHLY EXPENSES**	
Employment (take home)	$	Rent/Mortgage	$
Workers Comp.	$	Utilities (Gas/Electric)	$
Unemployment	$	Water/Sewer/Garbage	$
Child Support	$	Home/Cell Phones	$
Social Security	$	Food (Groceries/Meals Out)	$
VA/Pension	$	Car Payment	$
TANF/Welfare	$	Car Insurance	$
Utility Allowance	$	Gas	$
Self-Employment	$	Medical/Dental Expenses	$
Other Income	$	Clothing	$
Food Stamps	$	Household Goods (soap, etc.)	$
Grants/Loans	$	Entertainment (cable, movies)	$
		Child Care Expenses	$
		Education Expenses	$
TOTAL	$	**TOTAL**	$
MONTHLY INCOME - MONTHLY EXPENSES= $			

INCOME INFORMATION

Name of household member with income	List name of source of income	Phone Number (Of source of income)	Frequency (weekly, monthly, bi-weekly)	Day of week income received (Mon., Tues, etc.)	Total Gross Income In last 30 days

Please explain what happened that caused you to need/request assistance (i.e. unexpected expenses, loss of income, etc.):

_____
_____
_____
_____

The information provided above DOES NOT determine eligibility or financial assistance; this form is used solely to gather information.

I certify that I have truthfully completed this questionnaire and give permission to the CAP Social Services staff to verify all information, including prior assistance from other agencies.

_____ _____

Client Signature Date

AZCEND
Southeast Community Action Program
Confidentiality Policy

AZCEND - Community Action Program (CAP) staff recognizes the importance of the highly sensitive information given to them by their clients. The CAP staff will not violate the trust and confidence of their clients. Failure to adequately protect confidential information regarding CAP clients may be grounds for employee dismissal.

The following guidelines were designed to help ensure that privileged information is treated with confidentiality and respect:

- Client files will be stored in locked cabinets
- Access to files is limited to CAP caseworkers, AZCEND supervisory staff, and Maricopa Human Services Department-Community Services Division staff.
- Clients have the right to review their files. AZCEND staff must be present while a client reviews their files. Photo identification must be presented at the time of the request.
- Only applicants and their spouses (listed as a household member on the application) may view the files.

The following guidelines will govern the release of confidential client information:

- The "need to know" principle will govern which information will be released.
- Information will only be released when a client has authorized such release, as outlined on the client assessment form.
- Requests for client information from police or court personnel will be referred to AZCEND's CAP Program Manager immediately.
- Any questions related to the release of client information will be referred to AZCEND's CAP manager.

I have read and received a copy of the Confidentiality Policy as outlined above.

Client Signature: _____Date:_____

Caseworker's Signature: _____Date:_____

AZCEND
Southeast Community Action Program
Problem Solving Process

We hope your contact with the Community Action Program (CAP) is beneficial to you. If you feel, for any reason, you have been treated unfairly you have a right to seek a solution as outlined below.

Step 1: Discuss your concern with the CAP manager to try to reach a satisfactory solution. You can call 480-892-5331 ext. 106 to discuss verbally or schedule a meeting. You must contact the manager within 10 days of the problem occurrence. The CAP manager will document your complaints as well as any steps taken to resolve the situation. The CAP shall maintain the files and records relating to complaints for a period of three years. Such documents shall be maintained as confidential records. You may request a copy of this documentation.

Step 2: If you are dissatisfied with the results of your meeting with the CAP manager, you may present your complaint to AZCEND's Program Operations Director (480-963-14231 ext. 110). You must contact the Program Operations Manager within 10 days of completing step one. The Program Operations Manager will respond within 2 weeks of discussion and will document your complaint as well as any steps taken to resolve your complaint. You may request a copy of this documentation.

Step 3: If you feel your complaint has not been satisfactorily resolved, you may present your complaint in writing within 10 business days to AZCEND's CEO (345 S. California St. Chandler, AZ 85225 Phone number 480-963-1423). Upon review of your complaint, and in no more than 10 business days, you will be provided a written response addressing your concerns. AZCEND's CEO shall review all client grievances for the purpose of continuous quality improvement. A record of client grievances shall be kept as part of the Chandler/Gilbert quality improvement documentation. The CAP senior management and Board shall review as appropriate.

Steps 4: If you feel AZCEND's CEO has not satisfactorily resolved your complaint, you may present your complaint within 10 business days to the program administrators of the Maricopa County Human Services Department – Community Services Division at 234 N Central Ste. 3000, Phoenix, AZ 85004. Upon review of your complaint and within 10 business days, the Community Services Division staff will provide a written response addressing your concerns.

Step 5: If you feel the complaint is still unresolved by program administrators of Maricopa County Human Services Department – Community Services Division, you are encouraged to take the final step in the appeals process and present your complaint in writing within 10 business days to the Arizona Department of Economic Security, Division of Aging and Adult Services, Assistant Director, PO Box 6123, Site Code 950A, Phoenix, AZ 85005, Phone #: 602-542-6600, Fax #: 602-364-1756. Upon review of your complaint, staff will provide a written response addressing your concerns within 10 business days.

I have read and received a copy of the Grievance Procedure outlined above.

Client Signature: _____ Date: _____

MCHSD/CSD
APPLICATION INTAKE AGENCY
Enter Name/Address/Phone # of Agency

Chandler location	Gilbert location
345 S. California St	132 W. Bruce Ave
Chandler, AZ 85225	Gilbert, AZ 85233
480-963-1423 ext. 118	480-892-5331

CLIENT RIGHTS AND RESPONSIBILITIES

I understand that it is my responsibility to keep all appointments and to notify the Application Intake Worker if I am unable to keep my appointment.

I will provide all necessary documents and verifications as requested. In the event that I am not able to obtain a requested document or verification, I will notify the Application Intake Worker who will provide me with direction or assistance concerning this matter.

I understand that, without all necessary documents and verifications, an application for direct financial assistance cannot be processed.

I understand that I must provide full and accurate information regarding all persons in my home, to include income, resources, property and all other items that pertain to my household's possible eligibility for services.

I understand that failure to cooperate fully with the application intake process is grounds for denial of an application for direct financial assistance.

I understand that, if I believe my application should not have been denied, I may appeal this decision. I will notify this agency if I wish to appeal this decision or the quality of service I was provided. I understand that, upon request, I will be provided assistance with my request to appeal. If I have not already received one, I will request from this agency, a copy of their written appeal, grievance, or problem solving procedure. I understand that, if I wish to appeal, I or my authorized representative must do so in writing to this agency within ten (10) days of the receipt of the denial notice.

With my signature below, I confirm that I fully understand my rights and responsibilities.

_____

Applicant Signature Date